

# Developing the Patient-Centered Medical Home: Perspectives from the Practice and the State Levels

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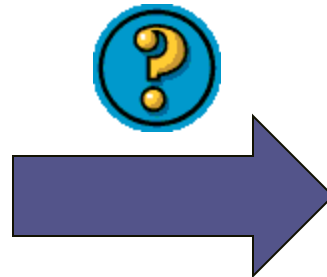
# Agenda

- PCMH Development: Where to start?
- The Practice Perspective: Lessons learned
- CMS MAPCP Background Information
- Michigan Primary Care Transformation Project
- MiPCT: Clinical Model
- MiPCT: How Will We Define Success?
- Summary



# PCMH Development: Where to start?

# How to Get From Here to There?



# It Helps to Have a Blueprint...



# PGIP and the Patient Centered Medical Home

- Key focus: Patient Centered Medical Home (PCMH)
  - Largest PCMH project in U.S.
  - Building the state's primary care foundation
  - Physician organizations take responsibility for PCMH implementation
  - Financial incentives for PCMH implementation, quality, cost
  - Collaboration is rewarded
- Currently in third year of designation process
- 505 PCMH-designated practices in 2010, 700 in 2011

# PGIP: Collaborative effort between BCBSM and Michigan POs/PHOs

- Relationship built on trust
- Mutual understanding that this work is very difficult
- Biggest challenges from the provider perspective
  - Need funding to build infrastructure before achieving results
  - Most difficult for solo practitioners
  - Transformation takes time and is incremental to existing work
- PGIP partnership solutions
  - BCBSM provides funding to build infrastructure first, results second
  - Acknowledge that we all make mistakes, and that “perfect is the enemy of good”



# The Practice Perspective: Lessons Learned

# University of Michigan Family Medicine: Our Clinical Environment

- Five clinical sites
- 140,000 annual visits
- 55 clinical/research faculty, 30 residents
- Provide full spectrum care, including obstetrics
- The challenge of academic medicine
  - Support clinical, educational, research missions
  - Demonstrate model that attracts students to primary care
- Initial clinic model (2005)
  - Practiced as individuals, no true team-based care
  - Challenges with continuity, coverage for absences
  - Population management not well developed

# Our Philosophy: Take a Focused, Phased Approach to Implementation

- Phase 1: Team development, role definition
- Phase 2: Point-of-care population management
- Phase 3: Population management and care coordination, access improvement

# Define and Expand Team Member Roles: Examples

- Nurse Practitioners/Physician Assistants
  - Involved in care coordination, access improvement
- Registered Nurses
  - More formalized role in care coordination
- Licensed Practical Nurses
  - Renew prescriptions based on delegation protocol
- Medical Assistants
  - Assist with chronic/preventive care during visits
- Outpatient Office Assistants
  - Call patients who need follow up appointments/testing

# The Role of a Registry: With the Right Tools...

- Must be fully integrated into clinic operations
  - Define team member registry roles
  - Use at point-of-care and for proactive outreach
- Must contain validated, up-to-date information
  - Garbage in => garbage out
- Many EMR vendors claim to perform registry functions, but few deliver
  - Most practices need both an EMR and a registry
  - Ideally, they should “talk” to each other

# Engaged Local Leadership is Key



# Strategies for Engaging Physicians and Staff

- Start with a vision
  - Personalize PCMH concepts to meet local needs
- Give people control over their environment
  - Don't be too prescriptive – let people be creative
  - Allow staff to participate in creating their job descriptions
  - Share successes and lessons learned across practices
- Anticipate, understand and address barriers
- Discuss changes in multiple venues
  - Communication is critical to success
  - Just when you think you can't say it one more time, say it one more time!

# Most Important Lessons Learned

- If a practice is in it only “for the money” they will have a harder time succeeding – NEED A VISION
- True practice transformation takes a long time
- Challenges may differ based on practice size
  - Smaller practices => financial challenges
  - Larger practices => operational challenges
- A shared learning network such as PGIP makes success much more likely
- Change is hard, but not impossible.



# **CMS Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project**

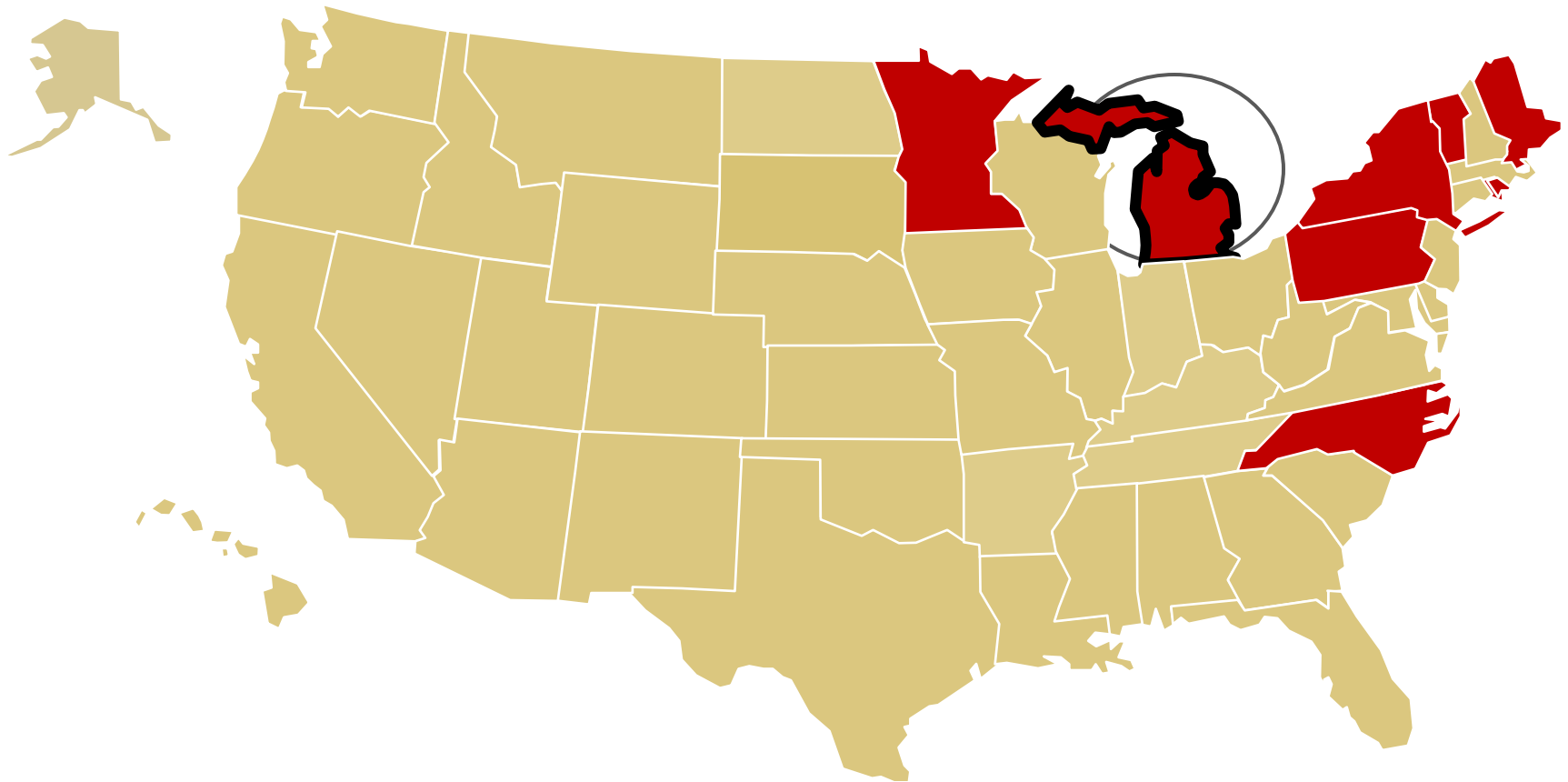
# Michigan PCMH-recognized practices (2010)

- Physician Group Incentive Plan (PGIP)
  - 505 designated practices
- National Committee for Quality Assurance (NCQA)
  - 7 Level 1 certified practices
  - 18 Level 2/3 certified practices
- This 2010 PCMH cohort forms the foundation of the Michigan multi-payer demonstration project

# CMS Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration

- CMS award notification: November 16, 2010
- 8 states selected for participation, including Michigan
- Built on BCBSM PGIP PCMH foundation
- Includes Commercial, Medicaid and Medicare patients
- Anticipated start date: October 1, 2011
- Financial stipulations
  - Michigan Medicare payment: \$9.76 PMPM
  - Must be budget neutral over 3 years of project
- Expect improvements in cost, quality, and patient experience

# MiPCT Foundation: Michigan's Selection for MAPCP CMS Demonstration Project



**■ = States participating in Medicare Multi-Payer Advanced Primary Care Project to realign payment incentives and build patient-centered medical homes**

Source: CMS, March 2011 (<http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=cms1230016>)

# MAPCP Demo: Participating States

• Maine	22 practices	→	42 (year 3)
• Michigan	477 practices		
• Minnesota	159 practices	→	340 (year 3)
• New York	35 practices		
• North Carolina	54 practices		
• Pennsylvania	78 practices		
• Rhode Island	13 practices		
• Vermont	110 practices	→	220 (year 3)
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• TOTAL	948 practices	→	1,259 (year 3)

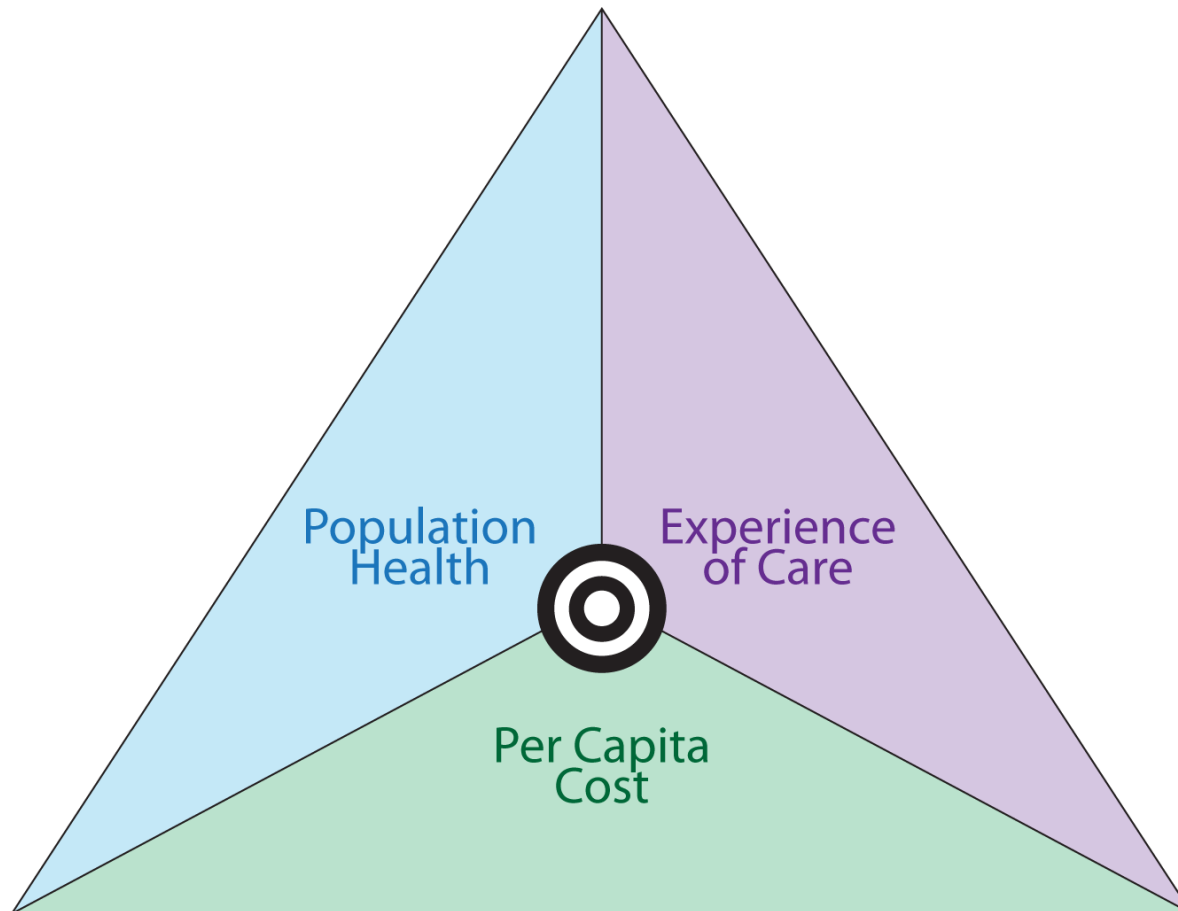


# The Michigan Primary Care Transformation (MiPCT) Project

# The Vision for a Multi-Payer Model

- Use the CMS Multi-Payer Advanced Primary Care Practice demo as a catalyst to redesign MI primary care
  - Multiple payers will fund a common clinical model
  - Allows global primary care transformation efforts
  - Support development of evidence-based care models
- Create a model that can be broadly disseminated
  - Facilitate measurable, significant improvements in population health for our Michigan residents
  - Bend the current (non-sustainable) cost curve
  - Contribute to national models for primary care redesign
- Form a strong foundation for successful ACO models

# Guiding Principle: The “Triple Aim”



# MiPCT: Stakeholders

• Invited Payers (unique # public/private):	17
• Invited PO/PHO/IPAs:	37
• PCMH Designated Practices (2010):	477
• Beneficiaries :	
▫ Medicare	358,000
▫ Medicaid (state FFS)	150,000
▫ Medicaid (managed care)	248,000
▫ Privately insured	<u>1,153,000</u>
▫ TOTAL Beneficiaries	1,909,000

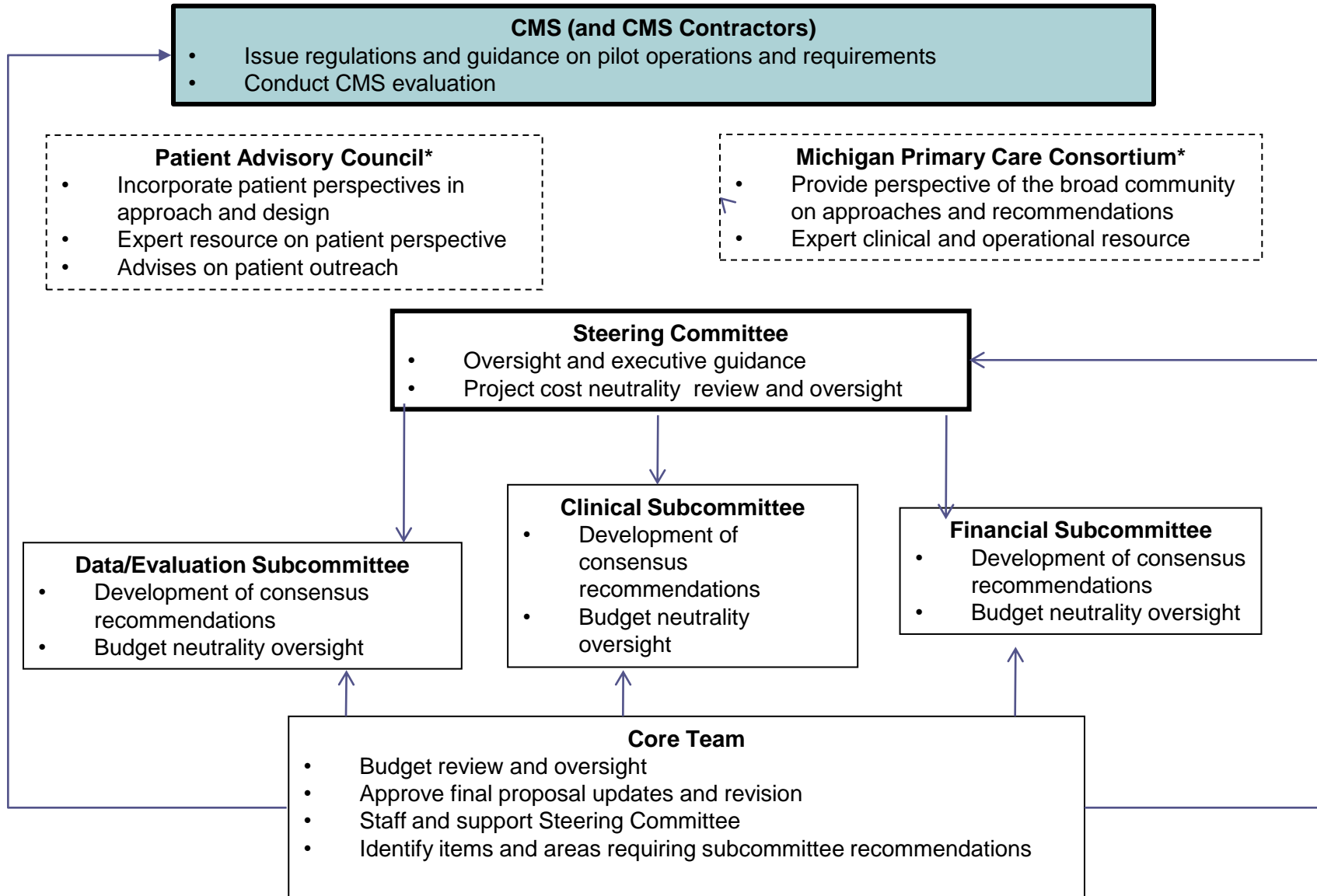
# Practice Participation Criteria

- Currently PCMH-designated, and maintain PGIP or NCQA designation over the 3-year demonstration
- Part of a participating PO/PHO/IPA
- Agree to work on the four selected focus initiatives:
  - Care Management
  - Self-Management Support
  - Care Coordination
  - Linkage to Community Services

# Engaging health plans to participate

- Challenges
  - No state mandate for participation
  - Economically challenged state, non-trivial cost
  - Model built on foundation of one major health plan
- Strategies
  - Include payers on steering committee
  - Engage purchasers (autos, etc.)
  - Equal voice for all participants
  - Flexibility, negotiation
  - Unwavering message that it's the right thing to do

## MiPCT Governance Model



\* Advisory Councils that may provide input or seek input from any committee, subcommittee, or the core team

# MiPCT Funding Model

\$0.26 pmpm	Administrative Expenses
\$3.00 pmpm*, **	Care Management Support
\$1.50 pmpm*, **	Practice Transformation Reward
<u>\$3.00 pmpm*</u> , **	Performance Improvement
<b>\$7.76 pmpm</b>	<b>Total Payment by non-Medicare Payers***</b>

\* Or equivalent

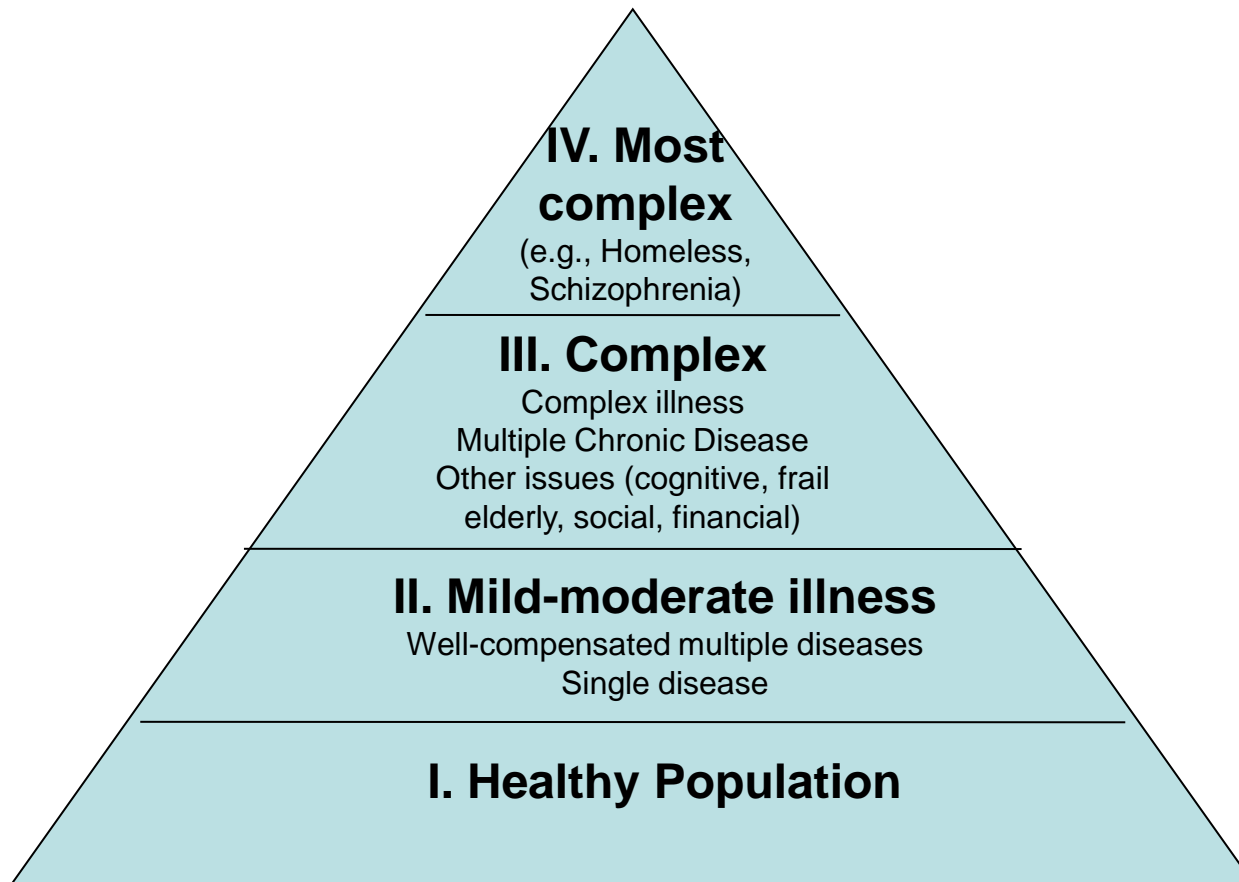
\*\* Plans with existing payments toward MiPCT components may apply for and receive credits through review process

\*\*\* Medicare will pay additional \$2.00 PMPM to cover additional services for the aging population



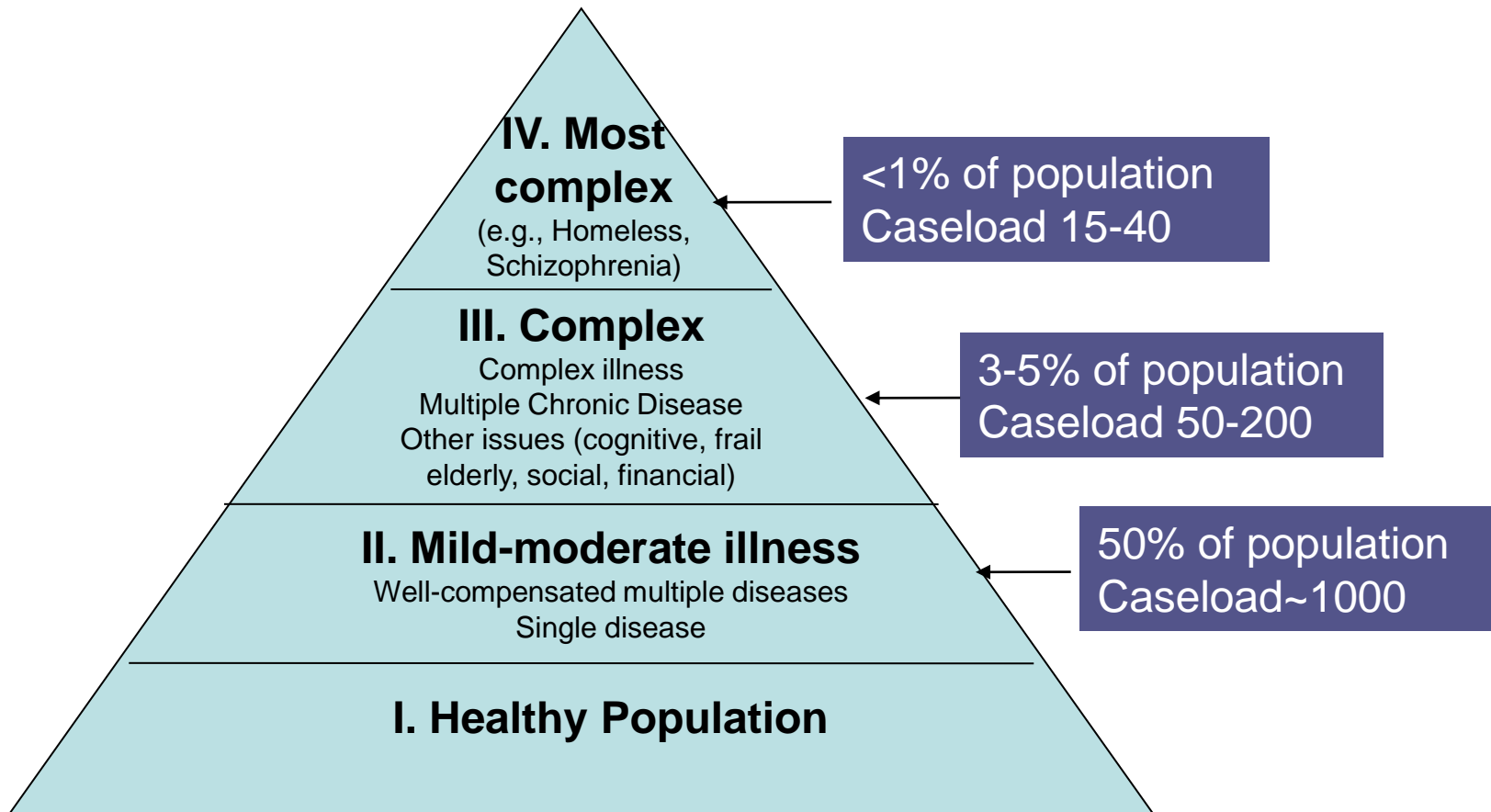
# MiPCT Clinical Model

# Managing Populations: Tiered approach to patient care



# Managing Populations:

## Tiered approach to care management



# Planning for short-term wins

- Need to achieving short-term cost savings yet always keep an eye on the long-term vision
- How to best accomplish this (i.e. where is the low-hanging fruit)?
- Need to rely on evidence-based approaches whenever possible, don't reinvent the wheel

# Some specific strategies for achieving short-term cost savings

- Identify appropriate high-risk patients for intensive care management
- Primary care access improvement to avoid unnecessary ED utilization and inpatient admissions
- Identify utilization outliers and perform focused root cause analysis
- Education on evidence-based approaches to care (i.e. management of low back pain)

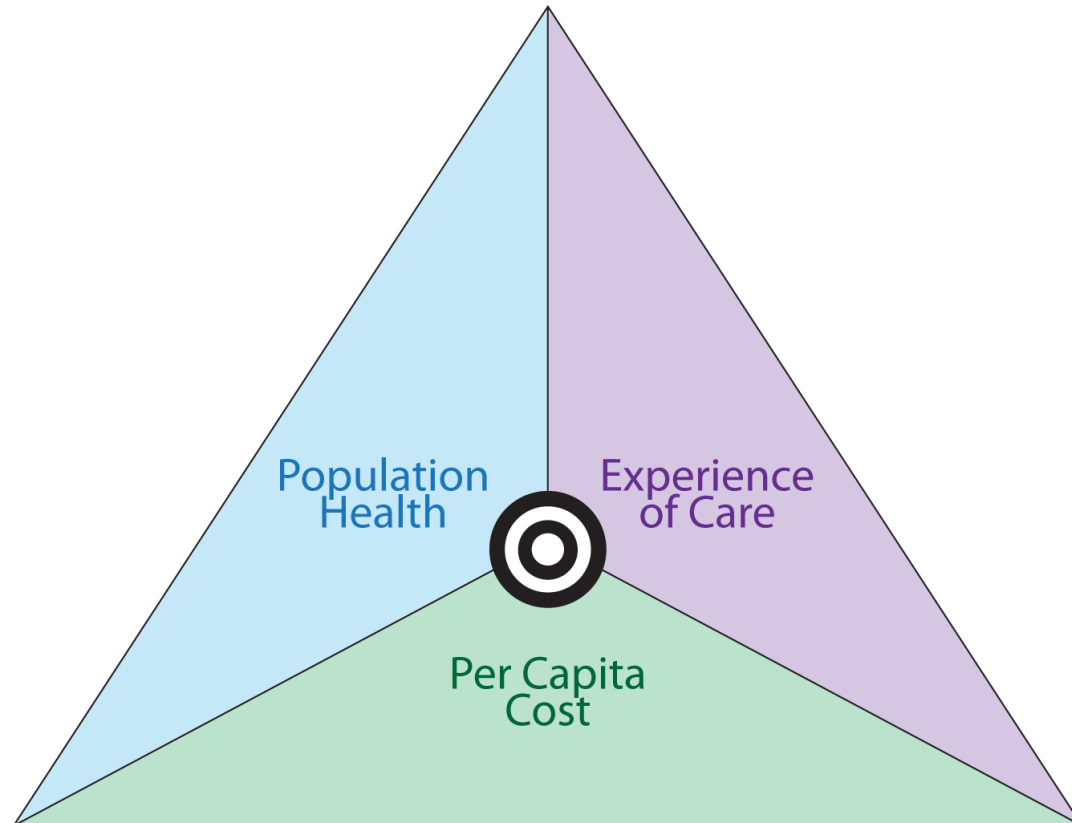
# Some specific strategies for achieving long-term improvement in outcomes

- Focus on all “tiers” of patient population
  - Healthy, moderate and high risk patients
- Recognize and reward performance on intermediate markers of chronic conditions to prevent long-term complications (BP in diabetes, etc.)
- Focus on primary prevention
  - Screening tests
  - Well-child exams, immunizations
- Work to build self-sustaining healthy communities



# How Will We Define Success?

# Success = Improvements in Population Health + Cost + Patient Experience



# Achieving Budget Neutrality: Projected Medicare Savings

Benchmarked Against  
Medicare National costs

- Inpatient 13% higher
- ED 22% higher
- Outpt imaging 25% higher
- Outpt procedures 30% higher

MiPCT Savings Category	Yr 3 PMPM Savings
IP: Admissions for Ambulatory Care Sensitive Conditions (3.1% reduction)	\$7.24
IP: Transitions of Care/ Re-hospitalizations (1.2% reduction)	\$2.82
ED: Primary Care Sensitive Conditions (2.6% reduction)	\$0.93
Outpatient (reduction in unnecessary use & shift to lower cost procedure mix)	\$6.49
<b>TOTAL PMPM SAVINGS</b>	<b>\$17.48</b>
Increased use: Office Visits & Preventive Services	-\$2.47
<b>NET TOTAL PMPM SAVINGS</b>	<b>\$15.01</b>



- True PCMH transformation takes time (and patience)
- Having engaged leadership is key to success
- It is helpful to partner with health plans who support PCMH development, not just achievement of certification/designation
- Patient care teams, access improvement and population-based registries form the PCMH foundation
- Care coordination and care management are more advanced functions that can lead to significant savings
- State-wide PCMH development is challenging but possible



Questions?